wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

(f) The hospital may advertise and otherwise disseminate information concerning the reduced level of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not allowed in any other ambulatory settings or physician offices.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001]

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the ''labor-related portion'' of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* CMS uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Outlier adjustment*—(1) *General rule.* Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under paragraph (e) of this section.

(ii) At the option of CMS, a fixed dollar amount.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) *Limit on aggregate outlier adjustments*—(i) *In general.* The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (d)(3)(i) of this section, the term ''applicable percentage'' means a percentage specified by CMS up to (but not to exceed)—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) *Transitional authority.* In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, CMS may—

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by CMS), rather than for specific departments within the hospital.

(e) *Budget neutrality.* CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

(f) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices of brachytherapy, consisting of a seed or seeds (including a radioactive source) are excluded from qualification for outlier payments.

(g) *Payment adjustment for certain rural hospitals*—(1) *General rule.* CMS provides for additional payment for covered hospital outpatient services not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—

(i) Is a sole community hospital under § 412.92 of this chapter; and

(ii) Is located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under § 412.103 of this chapter.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC, devices of brachytheraphy consisting of a seed or seeds (including a radioactive source), and devices paid under § 419.66 are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

(5) *Copayment.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating copayment amounts.

(6) *Outliers.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating outlier payments.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 47677, Aug. 3, 2000; 66 FR 55856, Nov. 2, 2001; 69 FR 832, Jan. 6, 2004; 70 FR 68727, Nov. 10, 2005; 70 FR 76178, Dec. 23, 2005]

§ 419.44 Payment reductions for surgical procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) *Terminated procedures.* When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; or

(2) One-half of the full program and the beneficiary coinsurance amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before anesthesia is induced.

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, CMS reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* CMS will consult with an expert outside advisory